CONCERN WORLDWIDE

Kibilizi District Health Partnership

CHILD SURVIVAL PROGRAM

S E C O N D A N N U A L R E P O R T

Kibilizi Health District, Butare Province, Rwanda

(FINAL)

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I. OVERVIEW

Rwanda is a densely populated land-locked central African country. This year witnessed the first presidential and legislative elections, representing an important step towards reconciliation and development since the turbulent recent history with much loss of life and destruction of infrastructure. Concern Worldwide started operations in Rwanda at the height of the crisis during 1994. All of Concern Rwanda's programs have a common overall goal: *the rehabilitation, development and promotion of social cohesion of Rwanda and its peoples.*

Concern Rwanda has been assisting with material and technical assistance in Kibilizi Health District since 1998. The district is located in Kibilizi Health District, Butare Province in south central Rwanda. In 2001, Concern Worldwide in Rwanda received the organization's second USAID Child Survival Grant to further develop and sustain this Rural Health Program.

A **problem statement** for the project is stated that - *the capacity of the District Health Team to deliver quality health services is compromised, and that without further development assistance, the health security of the rural vulnerable population in Kibilizi will continue to be extremely hazardous.* The Provincial Health Department does not have the capacity to develop the District Health system unaided. This CSP aims to continue the transition from relief and rehabilitation towards health development.

The project's broad goal is to **contribute to a sustainable reduction in maternal and child mortality and morbidity, and increased life expectancy for 75,000 women of reproductive age and children under-five years** in Kibilizi Health District, Butare Province. Specifically, the program purpose is to improve the health status of the population of Kibilizi District through capacity building for high quality and sustainable health services, and by empowering communities for better health with locally available resources. Focal interventions include HIV/AIDS, malaria, nutrition, and maternal and newborn care.

The Kibilizi Program *methodology* is based on the belief that long-term *health security is achieved only if people improve their knowledge and capacity* for better health. A participatory community development and capacity building approach for health where communities are empowered to reduce their health risks and recognize danger signs, and the district health care system is simultaneously strengthened at institutional level, is the proposed program methodology. Advocacy action will be undertaken with regard to specific issues relevant to this Child Survival Program.

Primary implementing partners are the Kibilizi District Health Team and Caritas staff, Community Health Workers, Traditional Birth Attendants, Health Committee members and the client population. During the second annual review, project staff and district health team partners reviewed the project objectives, second annual targets, planned activities, and available data to assess achievement and their factors as well as identify constraints and analyze options to overcome them. This report presents those findings and proposed workplan for 2004.

II. MAJOR ACHIEVEMENTS

During its second year, the Kibilizi Child Survival Program made visible achievements in the areas of establishing quality voluntary counseling and testing and prevention of mother to child services, coverage of mosquito nets to pregnant women, development of a curriculum for traditional birth attendants (TBAs) and training first set of 45 TBAs, launching of initial three community nutrition sites, successful advocacy for community malaria case management, and active participation in national IMCI working group.

A review of outcome objectives indicates that the program is largely on track toward its 2006 targets as shown in table 1 below.

Table 1: Progress towards outcome objectives, Kibilizi District Child Survival Project, September 2003.

Indicators	Baseline/ Year One	Target for Year Two (2003)	On Track?	Comments	End of Project Target (2006)
4. Increased by 50% STD consultations from baseline	134	154	Yes	During the first 9 nine months, a total of 133 cases had already been seen; at this rate, the program should reach at least 175 cases by the end of the 12 month period. Two health centers, Gikore and Kigembe, have doubled their clients since last year. However, services in other centers are stagnant. Resources for STD case management are very limited in this setting.	201
5. Increased proportion of adults who have been tested for HIV from 10% to 20%.	10%	12% (Target = 1533)	Yes	From December 2002 – July 2003, a total of 1517 adults have been tested at the two VCT sites in Kibilizi. Clients are largely women in the PMTCT program and young couples planning to marry. A stock out was experienced during this period and affected participation. The sustenance of supplies is critical if the district is to achieve its desired target.	20%
6. At least 50% of antenatal clients at Kansi HC participate in PMTCT service	0%	50%	Yes	Reports from March-July 2003 show that 700 of 780 antenatal clients have volunteered to participate in PMTCT at Kansi. This presents 90% of clients, far exceeding the target of 50%.	50%
7. Reached 40% of seropositive pregnant women who participate in the PMTCT program who administered niverapine according to standards.	N/A	40%	No	Data from March to August 2003, indicate that all 41 seropositive women in the PMTCT program received a dose of niverapine to be taken during labor. Most of the 33 women who delivered at home report having taken the dose. All 8 (20% of total) of the women who delivered at the health facility received a dose of Niverapine for themselves and administration for the newborn. More emphasis is needed on behavior change of women who are HIV+.	40%

Indicators	Baseline/ Year One	Target for Year Two (2003)	On Track?	Comments	End of Project Target (2006)
8. Increased the proportion of children age 0-23 months who were breastfed in first hour after delivery from 38% to 50%.	38%	42%	Likely	Unsure of status. Need to put more IEC effort on this issue and make sure optimal breastfeeding practices are clear at the PMTCT site. January 2004 population survey should give us a better indication of level of effort required here.	50%
9. Increased the proportion of children aged 0-23 months who slept under a treated mosquito net last night from 0.9% to 10%.	0.9%	5% (n=1457 new nets)	Yes	Large scale distribution of nets is underway and controls for use and re-impregnation reinforced. From April to July 2003, 1529 ITNs were sold to pregnant women through the antenatal clinics. This represents 25% of all pregnant women expected in the district in 2003.	10%
10. Proportion of women with children < 24 months with at least 2 doses of TT from 23.8% to 40%.	23.8%	28%	Yes	Based on GESIS data, about 28% of all pregnant women attended 3 or more antenatal visits, providing adequate opportunity to administer TT per standards. A few centers have seen substantial increases in the number of clients completing 3 or more visits while a few have seen stagnant or declining numbers. Coverage to be confirmed in population survey in January 2004.	40%
11. Increase the proportion of TBA clients referred to 15% due to complications.	N/A	15%	Likely	A total of 45 active TBAs have been trained on early recognition of complications through danger signs, covering a total of 3 of the 7 health center catchment areas. A monitoring system has only recently been put in place.	15%
12. Increased proportion of all deliveries that place at a health institution from 7.9% to 20%.	7.9%	11% (total of 935 deliveries)	Yes	GESIS data from October 2002 to July 2003 report 775 health center based deliveries. If the trend continued for the year, the target would be exceeded, reaching 13% of expected deliveries.	20%
13. CAPACITY INDICATORS District Health Team will demonstrate a measurable improvement in selected capacity areas prioritized during the baseline HICAP	TBD	TBD	TBD	Capacity assessment planned for November/December 2003	TBD

III. IMPLEMENTATION STATUS

a) Progress by Objectives

The Kibilizi Child Survival Program is working towards the establishment of seven critical outputs in order to achieve its overall purpose and goal related to improved health status of the population. These outputs are:

1) Improved District Health management system
2) Improved quality of HIV/AIDS, Malaria, Nutrition and Maternal and Newborn Care services
3) Increased health care coverage
4) Decentralized and institutionalized health services
5) Sensitized District Health Team and population on child and gender health rights
6) Empowered population for disease prevention and risk reduction
7) Improved Concern-CSP planning, design, and management capacity

The following section describes major activity-level achievements, constraints and way forward according to program experience in the second year.

1. Improved district health management system

CSP aims to strengthen the management system of Kibilizi District. This includes participatory management at all levels, information-based district health annual plans, community participation, effective supervision and human resources management, and proactive utilization of the health management information system (GESIS). By strengthening the management systems, the district should be capable of sustaining the efforts of CSP by the end of the program.

During its second year, key CSP activities planned under this output included joint development of Kibilizi District Annual Health Plan, forming the District COSA, improving the facilitation of monthly District Health Team (DHT) meetings, GESIS training, and strengthening the supervision system.

Table 2: Progress towards Output 1 objectives, Kibilizi District Child Survival Project, September 2003

Indicators	Baseline/ Year One	Target for Year Two (2003)	On Track?	Comments	End of Project Target (2006)
14. Quality annual district health plan with clear financing plan based on data from GESIS and the community.	0	1	Yes	A plan was developed jointly with the District, GTZ and Concern. It is reviewed quarterly. Data is now available for use in planning the 2004 plan.	1

Indicators	Baseline/ Year One	Target for Year Two (2003)	On Track?	Comments	End of Project Target (2006)
15. Increased to 7 the number of health facilities with functional COSAS (independently operational, and making bimonthly workplans)	7	7	Yes	Despite the absence of a clear definition of « operational» all 7 COSAs are working and meeting regularly. Training took place in 2003 on roles and technical areas. An 8th COSA was formed that will support the District.	7
16. Participatory monthly District Health Team meetings revolving among health centers with documented minutes and follow-up	0	12	Yes	The DHT is holding monthly meetings and the meeting format has been overhauled to broaden participation and direct discussions on substantial issues.	12

In December 2002, an action plan for the Kibilizi Health District was developed in collaboration with Concern and later inputs from GTZ. This plan effectively integrated CSP and District plans, identifying persons responsible, time frame, and budget. This plan was recognized by the Provincial Health, Gender, and Social Affaires Department and presented at a meeting in the presence of all the districts in Butare Province.

During the year, GTZ (as agreed through joint planning) trained 2 DHMT staff in GESIS and provided 2 computers to Kibilizi Health District. As a result of this training, health staff detected seasonal increases in malaria and malnutrition during the months of January – March 2003. Unfortunately Concern CSP staff were unable to participate in the training, although one staff member is highly conversant with the system through his previous employment with the Ministry of Health.

In August 2003, the District COSA was formed with 11 selected members including one representative of the Secretariat of Health, Gender, and Social Affaires, the two Mayors of Mugombwa and Kibingo Administrative Districts, the District Health Management Team, two health center representatives (one public and one private), two community representatives serving on local health center COSAs, and one member of Concern CSP staff. This body is charged to improve the management and participatory planning of the District Health System.

The District Health Team continued to hold coordination meetings on a monthly basis. Several steps were taken to make the meetings more productive. These included revising the protocol for the meetings (setting the agenda, reviewing minutes of last meeting, reports from each health center); progress report on implementation of planned activities; and broadening participation in these meetings to the two Executive Secretaries of the Administrative Districts. Key issues address by the DHT this year included planning for capacity building of the COSAs, standardization of mutuelles, and transportation priorities for the District.

Some constraints to progress include delays in establishing a routine quality supervision system, nascent state of the District COSA, and absence of the District Supervisor during the past 8 months of the year due to a transfer to Kibungo. In 2004, more concentration will be placed on the supervision system as a Supervisor has recently been appointed and

draft supportive supervision module drafted. The training module and proposed system will build on the supervision module developed in Kabutare District with support from HealthNet. Further, the District COSA will be supported with orientation to its roles and responsibilities, and management training. It will be the unit of analysis in the district health capacity assessment.

2. Improved quality of HIV/AIDS, Malaria, Nutrition and Maternal and Newborn Care services

The program aims to raise the quality of health services provided at the health facility and community provider levels. This includes institutionalization of continuous quality improvement and community participation in quality of its services. Training and follow-up in the areas of HIV/AIDS, malaria, malnutrition case management as well as maternal and newborn care is an important aspect of quality.

During its second year, CSP specific activities planned included training and supervision of 14 VCT counselors, strengthening supervision of malaria case management, and training traditional birth attendants on danger signs, clean and safe delivery and postpartum care. Table 3 outlines progress towards specific objectives under this output.

Table 3: Progress towards Output 2 objectives, Kibilizi District Child Survival Project, September 2003

Indicators	Baseline/ Year One	Target for Year Two (2003)	On Track?	Comments	End of Project Target (2006)
17. At least 65% of VCT pre and post consultations that meet minimum quality standards	n/a	50%	Yes	Treatment Research AIDS Center (TRAC) provides quarterly supervision to the district for its VCT sites. Supervision reports indicated some problems with laboratory tests which have been corrected.	65%
18. At least 75% of malaria consultations meet minimum quality standards	n/a	n/a	Likely	Supervision system not yet firmly in place. A good technical update was provided in 2002 for all health facility in-charges on the new malaria guidelines.	75%
19. At least 65% of children 0-36 months underweight who were counseled and referred appropriately	n/a	n/a	Likely	This is achievable among children participating in the community nutrition sites.	65%
20. At least 65% of health staff able / detect underlying illness(es) of malnourished children	n/a	n/a	Unknown	The project has not yet placed emphasis on this aspect. It should be reviewed with the promotion of the CB-GMP and referral nutrition sites.	65%
21. At least 60% of trained TBAs who accurately recognise at least 3 danger signs and minimum conditions needed for hygienic deliveries	n/a	n/a	Likely	Skill must be verified through assessments of TBAs. Follow-up with 3 TBAs indicated 100% knew 3 or more danger signs and conditions for hygienic delivery. These areas were well covered in the TBA training.	60%

Indicators	Baseline/ Year One	Target for Year Two (2003)	On Track?	Comments	End of Project Target (2006)
22. At least 65% of trained people assisting deliveries that provide minimum standard of care for newborns	n/a	n/a	Yes	Newborn care module was well covered in the TBA training; however, health center staff have not yet been trained. More follow-up and assessment on these aspects is needed in the year to come.	65%

As previously described, plans to improve supervision and quality of care were set-back due to district staffing and transport shortages. With these issues largely resolved, enhancing the supervision system will be a major area of emphasis in 2004. While the DIP proposes to conduct a district-wide quality of care assessment, there is a solid rationale to focus on building a routine supervision system that assesses key quality aspects related to the four intervention areas. Comparison over time of supervision reports can be used to measure change.

Completion of training and supervision of TBAs to all 7 health center areas will take place in the coming year. This community life saving skills intervention will be complemented with refresher training of health center staff on safe delivery and Basic Emergency Obstetric Care in collaboration with the Ob/Gyn Department at the Medical School and University Hospital in Butare.

3. Increased health care coverage

Accessibility of formal facilities in Kibilizi is a major constraint to utilization of services. CSP aims to strengthen outreach services, establish a quality district voluntary HIV/AIDS counseling and testing site (VCT), and enhance services provided by networks of community health promoters composed of trained traditional birth attendants (TBAs), Health Animators, and traditional practitioners.

During its second year, CSP specific activities planned included establishment of VCT and PMTCT services, distribution system for ITNs, training of TBAs in their health center catchment areas, and establishing a reporting system for Community Health Animators. Four new groups of traditional healers were formed during the year.

Table 4: Progress towards Output 3 objectives, Kibilizi District Child Survival Project, September 2003.

Indicators	Baseline/ Year One	Target for Year Two (2003)	On Track?	Comments	End of Project Target (2006)
23. At least 21 cellules with functional Community-GM program (at least 50% of children < 36 months participating)	0	3	Likely	Three site initiated in Gikore catchment area since June 2003 with 487 children participating. While clearly not yet 50% coverage, the number of targeted cellules participating in each GM catchment are is still being determined. Some basic services not yet operational as awaiting procurement of micronutrients and vermox.	21

Indicators	Baseline/ Year One	Target for Year Two (2003)	On Track?	Comments	End of Project Target (2006)
24. At least one functional VCT site available in the district	0	1	Yes	Two sites established. The remaining 5 health centers conduct VCT counseling and use Kibilizi and Kansi for laboratory diagnosis.	1

Kibilizi marked World AIDS Day on December 1, 2002 with the opening of its first VCT site at the Kibilizi Health Center. Preparations for the opening of this site included the training of 14 health staff in VCT with technical assistance from TRAC, procurement of supplies, and preparation of counseling space. A second site was introduced at Kansi's missionary health center in March 2003. The Kansi site also provides PMTCT basic services. Both sites were selected based on location and availability of skilled personnel. All 7 health centers have staff training in VCT and send blood slides for testing at the VCT sites daily. To date, a total of 429 men and 1,088 women have been tested through PMTCT or VCT services.

Table 5: HIV Voluntary Counseling and Testing Clients by Service and Site, Kibilizi District, December 2002 – July 2003

Service and Location	Women	Men	Total
VCT			
Kibilizi (Dec '02 – July '03)	222	201	423
Kansi (Mar – July '03)	166	228	394
PMTCT *(at Kansi)*	700	n/a	700
TOTAL TESTED	**1088**	**429**	**1517**

The PMTCT service is very popular among residents and was praised during community input in the annual review. During its first six months, 90% of the 780 antenatal clients have accepted to be tested. The seroprevalence rate of these pregnant women from the Kansi PMTCT program is 9.7%, which is slightly higher than the 7-8% national average for rural districts. Experience with niverapine administration among pregnant women has been fairly good with 41 mothers receiving niverapine with instruction on how to take it during labor. Only about 20% of these mothers delivered at Kansi HC, all of whom correctly received Nvp. Themselves and administration to the newborn. While most of the surveyed HIV+ mothers reported taking the Nvp. while in labor at home, 80% of the newborns missed the opportunity to receive added protection through a direct dose of niverapine. Better understanding the factors of low institutional deliveries among HIV+ mothers and identifying more effective strategies for ensuring oral administration of Nvp. for the newborn will be a research priority in 2004.

The quality of the testing services was initially compromised due to unavailability of 2nd tier rapid tests nationally which resulted in large numbers of undetermined cases. This was corrected largely in part to an express donation from Trinity Laboratories in Ireland of Goldstar reagents. Two laboratory technicians received further training in Kigali with

TRAC to ensure quality standards. Since this training and supply improvement, the status of all clients has been determined.

In April 2003, subsidized ITNs were provided to all 7 health centers in Kibilizi. Within three months 1529 nets were distributed to antenatal clients, representing nearly 25% of all expected pregnant women in the District in 2003. A follow-up study found that 96.5% of all nets are with the target group, suggesting minimum misappropriation of the nets. The initial assessment indicated that 71% of the nets were hung over the mother's bed and 62% of the nets had been treated. Findings were shared at the DHT in July and a strategy to have expecting mothers treat nets on site at the health center has been established. This is further described in the special **highlights** section at the end of the report. A second survey is planned in October 2003.

There has been a positive response by community members to this antenatal care distribution system. However, coverage of nets requires a system accessible to non-pregnant women as well. The project is working with the District to explore possibilities of selling nets at cost through the health centers to enhance accessibility. This has been raised by mutuelle members and was evident during a localized mosquito infestation in a neighborhood in Kigembe in August 2003.

In June 2003, the first three community based nutrition sites were opened in Gikore health center. The area was selected due to high levels of malnourished children participating in the nutrition rehabilitation center and strong nutrition expertise of the Activist facilitating Concern's work in the area. The three sites cover a target population of 1518 children under 36 months of age. During its first two months of activity, 487 children have been registered. A high level of malnutrition has been identified with about 58% of the children less than 2 Z-scores weight for age. These levels are similar to those found for Kibilizi in a 1999 Concern Worldwide nutrition assessment. Logistic preparations are under-way to include de-worming, iron and Vitamin A supplementation to registered children. A user fee of 50 Rfw has been agreed with the mothers and local leaders for these services. Exemptions for orphans and destitute families will be established by a local nutrition committee.

Alternative and sustainable methodologies for child nutrition are desperately needed. This year witnessed the closing of 30 years of food supplementation to the HC rehabilitation centers the country. Several centers were closed completely in Kibilizi. As the community nutrition component goes to scale to the next 14 sites in 2004, some adjustments are proposed to better follow the wisdom expressed in the DIP. The sites will be initially targeted to the population residing in the selected cellule (village) rather than the sector level. While this will initially reach fewer children, it will allow better tracking and promotion of all children under-36 months and to adopt a positive deviance/hearth approach to rehabilitation of to more closely follow-up on those who are malnourished and/or growth faltered. Three project staff and partners have are registered to participate in the CORE/World Relief training on the methodology in October 2003.

4. Decentralized and institutionalized health services

With the aim of enhancing the population's control and ownership of their health, CSP fosters the development and/or strengthening of decentralized health services. These

services include Health Service Committee (COSAs), local social insurance funds "Mutuelles", associations of community health providers, and Anti-AIDS clubs.

During its second year, CSP specific activities planned included community campaigns for social insurance schemes for health or mutuelles in all health center catchment areas, formation of mutelle committees, refresher training for all 7 health center-level COSAs for 3 days in August 2003, and capacity building of local associations for community health workers, TBAs, anti-AIDS clubs, traditional healers and persons living with HIV/AIDS (PLWHAs).

Table 6: Progress towards Output 4 objectives, Kibilizi District Child Survival Project, September 2003.

Indicators	Baseline/ Year One	Target for Year Two (2003)	On Track?	Comments	End of Project Target (2006)
25. At least three mutuelles are providing health insurance services at Health Centers with a participation of > 30% of eligible households		2	Yes	In 2003 the following health centers exceeded 30% participation : Kibayi (59%), and Mugombwa (50%). Participation is growing in Gikore (23%) and Kansi (22%). Much lower levels are found in Kirarmbogo (4%) and Kigembe (2%). Kibilizi's mutuelle remains non-existent due to lack of community interest despite two campaigns.	3
26. At least 70% of health centers actively engaging associations of traditional practitioners, TBAs, A/S, and PLWHAs			Yes	All 7 health centers have active groups of community health workers and TBAs meeting monthly, Each of these groups has either developed or is in the process of developing a constitution and contributing membership fees for group benefit. Groups of traditional healers have been formed in 5 health center areas. Three informal associations of persons living with HIV/AIDS are in place and a fourth is forming in Kibilizi. All HCs except Kibayi have at least one Anti-AIDS club. See Table 7 for further details on these groups.	70%
27. At least 80% of A/S who are actively working in the community and reporting monthly.			Likely	As mentioned above, all health centers have active groups. Orientation on the community health reporting system is just under way and should be functional very soon.	80%

A major issue identified by community representatives and group members is the cost and operations of the local mutuelle system. Differences in benefits and costs across health center areas are sources of potential conflict and low participation. In addition many mutuelles were operated by the health center staff and not a local committee comprised of members themselves. Concern is very aware of these issues and has participated in national working groups to share experiences, identify best practices, and develop guidelines for mutuelles in collaboration with the Ministry of Health and PRIME II. Plans are underway to standardize the operations of the mutuelles in Kibilizi District and to explore rolling membership fees in partnership with the Banque Populaire of Rwanda.

Table 7: Health-related Associations Monitor for Kibilizi District, August 2003

Health Center Catchment Area	CHWs	TBAs		AIDS Groups		Trad. Healers
	Strength of CHWs Association (1-4)	Number of TBAs trained	Strength of TBAs Association (1-4)	Number of Anti-AIDS clubs	Number of PLWHA associations	Number of Traditional Healers' Groups
Kigembe	3	--	2	2	1	1
Kirambogo	1	--	1	4	--	1
Gikore	1	--	2	1	--	
Kibilizi	3	15	3	1	⊕	1
Kansi	4	15	2	2	--	--
Kibayi	3	--	1	0	--	--
Mugombwa	3	15	3	2	1	1
Totals	**2.57**	**45**	**2.00**	**12**	**2**	**4**

Notes: Strength of association is based on 4-point scale for participation, financial contributions, and development of constitution.
⊕ Formation of group under-way

While much credit is merited for work done to form and strengthen these groups, a few critical issues raised by the project staff and partners during the annual review included:

- **Low involvement of health center personnel at several sites in working with these groups:** Several health facilities are understaffed while others do not share the sense of responsibility for community groups. Over the coming months, CSP will further engage these groups in data collection and analysis with health center personnel. By promoting the usefulness and recognition of having better information about their communities, the project will try to instil a stronger sense of value of working with local groups. Concern will work with the Health Management Team to strengthen its relationship with the new Health Secretary for Caritas in the Province to promote better partnership.

- **Missed opportunities to strengthen groups of PLWHAs:** These associations are still very young but are growing quickly in membership and scale. The Kansi group has been successful in attracting seed funds for income generating activities. Both groups are comprised solely of persons with HIV and exclude potential friends of PLWHAs. Other groups in the province have successfully integrated these two groups to strengthen and enhance social acceptability of PLWHAs. In late October 2003, a select group of project staff and partners with visit TASO and care and support programs in Uganda to identify opportunities to better support these groups. The project staff and partners will also seek further information about CARE's REACH care and support project in Gitarama.

5. Sensitized District Health Team and population on child and gender health rights

CSP envisions a district and community leadership that is well informed and active to transform gender and child inequities facing male and female members of society. To achieve this output, leaders must be familiar with child and human rights and key issues

in their communities, and facilitated discussions between community members about these issues will be needed.

Progress Indicators from Logical Framework
28. Transformation change in attitude of men and women on 1-2 agreed gender issues emerging from Gender and Health Study
29. Increased understanding of gender and child rights among district administration and health authorities in Kibilizi

During its second year, CSP specific activities planned included dissemination of findings of health and gender study at national and local levels with the local authorities. Dissemination included sharing at the CSP working group in Kigali in May 2003, presentation at CORE in April 2003. Local dissemination included a Provincial presentation in July 2003 for 26 persons including District Medical Officers, PSI/Dushishoze Youth Center, the Butare School of Public Health, the Provincial Department of Health, Gender, and Social Affaires, HealthNet, and representatives of Concern staff working in the region. Positive political support for gender has led to strong interest in local government leaders and NGOs in these findings.

This was followed by health center-level sharing meetings with local leaders, mutuelle and COSA members, health volunteers, and the general public. Each session lasted nearly 3 hours with very animated discussions and ideas about how to address gender in their community. Participation ranged from 40-65 persons at each session. While much interest was stimulated in the findings, participants requested further support from Concern to share these issues with the community and help to stimulate change. Specific local plans did not yet stem from these briefings.

As a result of the study and feedback from local groups and stakeholders, it is proposed to focus indicator #28 on improving ownership of decision making among women regarding key health issues as follows:

- Increase from 44.2% to 60% of adults who state that a woman either alone or jointly with her husband decides on expenditure of the household income.
- Increase from 25% to 60% of adults who state that the decision to attend antenatal care rests with either the woman alone or jointly with her husband.
- Increase from 31.7% to 60% of adults who state that the decision of place of delivery for pregnancy resides with the woman alone or jointly with her husband.

For the coming year, Concern and Kiblizi Health District will both identify a leader for gender and rights promotion in the district. A second provincial meeting will be held to share feedback from the community briefings, further discussion the implications of these findings, and develop a clear action plan to expand on a few key themes identified from the study.

6. Empowered population for disease prevention and risk reduction

By the end of this program, CSP expects to have raised the capacity of local institutions about disease prevention and how to reduce risk from contracting HIV/AIDS, malaria, malnutrition, and death or disability from obstetric complications. The wider BCC

objectives are to: 1) To reduce and prevent endemic communicable diseases and common mother and child health problems in Kibilizi Health District; and 2) To manage and treat appropriately, and to refer promptly the risk problems related to STI/HIV/AIDS, malaria, malnutrition and maternal and newborn care.

During its second year, CSP specific activities included support to anti-AIDS club outreach events, refresher on HIV/AIDS for 2-days for 200 local school teachers, and refresher training on malaria for 204 sector and cellules leaders.

Table 7: Progress towards Output 6 objectives, Kibilizi District Child Survival Project, September 2003

Indicators	Baseline/ Year One	Target for Year Two (2003)	On Track?	Comments	End of Project Target (2006)
30. Increased proportion of adults aged 15-49 who correctly identify at least two known ways to reduce risk of transmission of HIV/AIDS from 24% to 80%.	24%	35%	Yes	This information is being delivered through education messages of Anti-AIDS Clubs, local leaders, and more recently teachers. However, a huge increase in awareness is required to move from 30% a 80% by the end of the project. Need to assess practical knowledge level in January 2004 population survey.	80%
31. Increased proportion of adults aged 15-49 who correctly identify at least two danger signs of malaria to 50%.	n/a	n/a	Likely	Work already under way to inform health volunteers, leaders, teachers, and community nutrition participants about the basics of malaria, including signs and symptoms. Need to assess practical knowledge level in January 2004 population survey.	50%
32. Increased proportion of adults aged 15-49 who know that Vitamin A reduces risk of mortality in the child to 60%	n/a	n/a	Likely	The Ministry of Health, UNICEF and USAID have recently updated the National Vitamin A strategy which embraces this message. With support of mass communications and local communication efforts through the project, this can still be achieved.	60%
33. Increased proportion of adults aged 15-49 who correctly identify danger signs of malnutrition and appropriate actions for care to 60%.			Likely	Community based nutrition component has started and provides an excellent opportunity to improve awareness of danger signs as well as appropriate actions to be taken. Project needs to identify specific communication strategies to ensure all adults get this information. Need to assess in January 2004 population survey.	60%
34. Increased proportion of adults aged 15-49 who correctly identify at least two maternal danger signs to 60%.			Likely	All TBAs and health workers are familiar with key maternal and newborn danger signs. Need to work on communication strategies to ensure these are disseminated to the public. Need to assess in January 2004 population survey.	60%

The behaviour change strategies have not yet been developed with full participation of project staff and partners. Now familiar with the BEHAVE framework and strong formative research on the four intervention areas, these strategies will be refined for key behaviours in the coming year. With the support of local groups, leaders, teachers, and health personnel, the potential to promote change in knowledge and practices has good potential.

7. Improved Concern-CSP planning, design, and management capacity

In order to scale-up and spread learnings from CSP, Concern aims to strengthen its own capacity in planning, design, and management of district health programs. This includes promotion of cross-learning, continuing education, engagement in policy and standards, and documentation of experience.

Table 8: Progress towards Output 7 objectives, Kibilizi District Child Survival Project, September 2003.

Indicators	Comments
35. Documented trimester CSP meetings where staff review, analyze and plan future activities	In August 2003, the project staff and partners conducted their first quarterly data analysis by health center catchment area and worrkplans to identify successes and priority areas. This followed to completion of its functional monitoring system based on basic data from the GESIS.
36. Increased technical competency level of CSP staff in the areas of HIV/AIDS, malaria, nutrition and maternal and newborn care	Project staff have received training on all 4 technical interventions and have access to regular updates and refreshers.
37. Increased quality of performance objectives established and achieved by CSP staff	Performance management system in place and recently completed first cycle of assessments and planning.

During the year the following capacity building events took place:

Management

- Monthly CSP working group meetings
- Adult education methodology for 20 people for 5-days by Robb Davis of FFI
- Orientation on BEHAVE Framework for all staff for ½ day
- Strategic planning workshop for all staff for 1 day plus participation of Acting Project Coordinator in full process
- LQAS training with IRC for 2 staff for 7 days
- Security code training for 1 staff for 3 days
- Participation in national meeting to standardize mutuelle operations for 1 staff during 5 days
- Participation in CIFRA/GTZ training on public health and action research during six weeks for 1 staff
- Workshop on Guide for Mutuelles in Byumba and Kabgayi organized by PRIME II for 5 days with one staff and one district partner attending
- SPHERE standards training for 1 staff for a day

Intervention Areas

- Nutrition counseling for 11 staff and 10 district partners for 5 days based on FFI/Linkages Nutrition Education Module
- HIV/AIDS information and counseling for 6 staff and 2 district partners for 5 days based on FFI/WR HIV/AIDS Education Module
- Voluntary Counseling and Testing training for 10 days 11 staff and 17 district partners
- National Vitamin A Planning Workshop for 1 staff for 3 days
- Participation and presentation at CORE FreshAir Malaria Workshop in Bamako for 1 staff
- Training on malaria control and ITN strategy for 1 days by NMCP for all staff
- New Perspectives on Malaria conference for 7 days one staff

Exchange visits

- Gakoma District ITN strategy for pregnant women day exchange visit by 9 staff and 8 district partners
- Community malaria visit to Western Kenya for 3 staff 7 partners for 6 days
- TBA learning visit to IRC Child Survival Program in Kibungo 2 staff 7 partners to complete TBA training curriculum
- Nutrition learning visit to IRC program in Kibungo for 2 staff and 7 district partners to prepare for the Community Nutrition Program.

While generally speaking training opportunities have been very useful and high quality, a few issues were not covered comprehensively enough including strategic planning and behavior change communications. More support is needed in these areas in the coming year.

b) Technical Assistance Needs

The CSP Kibilizi received substantial technical and administrative support in year two. This support included review of nutrition, malaria and maternal and newborn care strategies, orientation to BEHAVE framework for strategic behavior change communications, training on LQAS methodology, establishing tools for monitoring and evaluation system, financial review, and second annual review. This included a total of three visits from the Technical Backstop and one from the Admin/Finance Backstop in year two. Local technical support was received from TRAC in the training of voluntary counseling and testing counselors and regular supervision of testing sites.

Future areas of technical support required include:

- Health Institution Capacity Assessment Process (HICAP) for Kibilizi District Health Team
- Assessment of staff technical competency and professional development planning
- Community empowerment and participatory planning and assessment
- Supportive supervision
- Refining behaviour change communications strategies
- Midterm process evaluation

- Best practices in care and support interventions for PLWHAs

Concern Worldwide will source technical assistance within Rwanda, East Africa and through its Child Survival Technical Advisor to fulfill some of these needs. Concern Worldwide in Bangladesh staff will support the project in designing an organization capacity assessment tool that brings together the structure of the MOST tool and the exploratory nature of the HICAP tool in November 2003.

c. Suggestions from DIP review

During the expert review of the Concern Rwanda CSP Detailed Implementation Plan, several recommendations were made to the field team and partners to consider and to enhance the overall performance of the program. In this section we respond to inquiries about how the program is addressing five key issues of:

i) Modalities of partnership with the National Roll Back Malaria Initiative.

The National Committee is yet to be established. With support from USAID and WHO, a national coordinator has been identified and is expected to report for duty in October. Barring the formal establishment of the RBM, Concern Worldwide, at times through the Child Survival Working Group (CSWG) has developed a close working relationship with the National Malaria Control Program during the year. This includes participation in the sharing of NGO efforts in malaria in various geographic areas of Rwanda on May 31, the joint design of a community malaria intervention study allowing health volunteers to provide front line malaria treatment to children aged 2 to 59 months combined with a collaborative learning visit to Western Kenya to learn from their experience (supported financially by CORE Inc.), and broad consultation in the establishment of an effective ITN strategy. Recently the National Malaria Control Program has attended the CSWG's regular meetings in Kigali.

ii) Research into feasibility of training shop assistants to dispense malaria medicines to be conducted

Positive steps in a more supportive political environment towards community case management of malaria was made this year. In 2003, the National Malaria Control Program developed a concept paper for community malaria control and prevention which was accepted by the Ministry of Health upon the grounds that it learns more about the experience from neighboring countries and pilots community distribution strategies.

In early July 2003, Concern in collaboration with CCF/Kenya, organized an exchange for learning visit to Western Kenya where they visited project sites from CARE in Siaya District, World Vision in Teso District, and Bungoma District Malaria Initiative supported by AMREF. The primary learning objectives of the visit were to: a) learn about the health worker, vendor-to-vendor, and neighbor-to-neighbor models for community distribution of front line malaria treatment; b) analyze the advantages and disadvantages of clinic and community based distribution approaches for malaria treatment; and, c) Identify key lessons learned in developing and implementing community based malaria programs applicable for Rwanda. Through this visit co-sponsored by Concern and the

Belgium Cooperation, the multi-institutional private-public team advised the government that malaria case management at the community-level is feasible in Rwanda under strong training, supervision and monitoring conditions.

CORE Inc. is planning to provide financial support for this collaborative action research where IRC, Concern, and World Relief will identify one Health Center catchment area for piloting the Health Volunteer front-line malaria case management approach.

During the year, Concern lobbied local government and leaders about the lack of any pharmacy in the district. As a result, two small private pharmacies have been established near Mugombwa and Kigembe health centers.

Despite this success, many areas remained underserved. Concern will work with the District to identify these areas and request the establishment of more pharmacies and/or the scaling up of health worker distribution areas (piloted in one health center catchment area in 2004) to ensure equitable access by the entire population.

iii) Indicators are too exhaustive and should be streamlined and focused on practices

This issue was addressed in year one with a modified set of indicators. A population survey is planned for January 2004 which will include comparative data to that collected in Kibungo Region with IRC support and Kilyombera District with World Relief support. See the section on monitoring and evaluation in Part III for further details on application in the monitoring cycle.

iv) TBA training details are not discussed in adequate detail

Preliminary curriculum was developed by Concern in Rwanda this year under the guidance of Dr. Sibumana Jean Claude, OB/GYN at the University of Butare. This is a comprehensive document building on the short 5-page TBA training points from the MoH used by IRC to train TBAs in 2000. Due to precipitation of activities, the project was not able to wait to develop the curriculum with national partners as we were awaiting the recently approved Reproductive Health policy. Concern has shared with curriculum with the Reproductive Health Division of the MINISANTE and hopes that it will serve as a starting point in the development of a revised national TBA curriculum.

The curriculum is composed of the following lessons aimed to be delivered over 5 ½ days:

- Anatomy of reproductive systems of women and physiology of pregnancy
- Antepartum period
- Labor
- Delivery
- Complications that can arise
- Breastfeeding
- Vaccination
- Postpartum Consultation
- Family Planning
- Sexually transmitted infections/HIV/AIDS
- Malaria
- Code of conduct for TBAs
- References

Training of 3 batches of 15 TBAs each was completed in April – May 2003. The lead trainer was Dr. Sibumana Jean Claude with TBA training experience supported by a District Health Team Nurse-Midwife, and the CSP Capacity Building Officer. Follow-up with trained TBAs indicates that there was a good understanding of new information and application of these learnings, notably in the persuasion of family with women experiencing complications or risk factors, hygienic delivery practices and in postpartum home visitation.

This training is complemented by monthly TBA meetings at the Health Center for refresher training, raising questions and finding answers, and reporting takes place.

v) Can private sector be included in the program in a positive way?

Several potential approaches were identified in the first annual report. These included: a) Promotion of licensed pharmacies; b) Solicitation of Sponsorship Support from Private Sector; c) Collaboration with Population Services International; and, d) Social marketing of clean delivery kits. Progress has been made on all fronts with the exception of point c, as the bed net distribution strategy has been revised as described in section II.

As mentioned under the second point, progress has been made in establishing the first two private pharmacies in the district in fairly remote areas. Concern will continue to advocate for further coverage of the district by private pharmacies.

Work is under-way by the Administrative Authorities of Kibingo and Mugombwa to identify potential private sponsors to support health activities in the District, including support for emergency ambulatory services, financing of indigents, and financial support for associations of persons living with HIV/AIDS. Relationship building and lobbying will be beginning in the coming year.

Socially marked basic clean delivery kits containing soap, razor blade, cord tie, and gloves have been established and will be ready for the market through antenatal clinics and by traditional birth attendants by the beginning of October 2003. The cost of these kits comes to just under US$ 1. CSP will work with local association(s) to replenish and market these kits.

d) Significant changes in design

A few important changes in project methodology that differ from original plans outlined in the DIP were made in the project in response to the current situation. These changes were under the interventions of malaria and maternal and newborn care.

The past seven years have been marked by unimpressive coverage of net ownership in Rwanda (3% in 1996 to 7% in 2003). Despite heavy social marketing nationwide, financial access to mosquito nets in Rwanda is a major determinant to household utilization. The health benefit of protecting pregnant women and young children with insectide treated nets (ITNs) is widely recognized in the prevention of maternal malnutrition and associated obstetric complications, stillbirths, low birth weight babies. Further, it is known that high treated net coverage in communities protects even

households without nets from the risk of malaria transmission (Hawley H. et al., Amer. Journal of Tropical Medicine and Hygiene, 2003). In 2003, the Rwanda government shifted emphasis from social marketing to highly subsidized mosquito nets through antenatal care services (ANC).

Having investigated appropriate strategies in light of obvious financial accessibility issues raised from baseline studies in Kibilizi, Concern worked with the National Malaria Control Program (NMCP) to procure low cost nets and treatment kits. The nets were further subsidized by Concern using match funds so they could be sold at the government's standard of 200 Frw (about $0.25). The subsidy is financed by funds for condoms which are now provided free of charge by USAID. Over its first few months, this strategy has proven to be highly effective in increasing coverage and use among intended beneficiaries as described in the special highlights section of this report.

A second important change was the precipitation and establishment of voluntary counseling and testing sites and the introduction of PMTCT. As described in the first annual report, tremendous demand from adults in the district, the availability of technical assistance from TRAC, and incoming resources from the Bush Initiative and other international donors for supporting persons living with HIV/AIDS, led to the establishment of two VCT sites and one PMTCT site in the district. As shown described under output 3, demand and quality of services has been strong.

No significant changes have been made in level of effort under the four intervention areas, budget category allocations, or beneficiary population. In June 2003, the Project Coordinator resigned to serve as the Maternal & Child Health Officer at the local USAID mission. His predecessor has been approved by USAID/Washington and is expected to report to duty in November 2003.

III. MANAGEMENT

a) Financial Systems

Basic systems in terms of finance and administration guidelines are in place and implementation monitored in the Country Office. Quarterly financial reports are submitted to Dublin and New York. Concern Worldwide US submits quarterly financial reports to USAID/W as required under this agreement. Monitoring reports from New York combining HQ and field expenditures were recently instated to track expenditure patterns and allowable charges.

A summary of expenditure against budget indicates that 82% burn rate against project budget to date with 1/3 of all expenditures matched with Concern funds. A budget revision might be necessary given higher expenditure in the categories of equipment and travel and lower expenditure in expatriate salaries and benefits during the initial project period. The financial situation will be further reviewed and revised according to the findings and recommendations from the mid-term evaluation.

b) Human Resources

There has been some staff turnover during the second year of the project at the field level. This has resulted in strain on project activities and project leadership. The majority of staff leaving the project received higher compensation offers from national health programs. It is important to note that many former staff are in positions to support the program at USAID and within the Provincial District Support and HIV/AIDS control program. Replacement of vacant positions has been expedient and has included a few promotions within existing staff.

In 2002, Concern Rwanda re-initiated its comprehensive performance appraisal system which is built on individual job descriptions, semi-annual objectives, and professional development priorities. The system is linked to salary increment increases. The first full performance review cycle has been completed. As described under progress in output 7, positive and focused efforts have been made to ensure staff have requisite skills to perform their functions.

c) Communication system and team development

Positive team building has taken place in CSP and with its partners. The team have conducted several national cross-visits together and supported each other during the start-up phase of the program. Communication systems are generally good between the Kigali and Butare offices and within the project team. The team meets for short weekly meetings to review planned worked and upcoming events. The Kibilizi District Health Team participated in the second annual review and planning for the organization assessment.

The management style is supportive of its staff and encourages participation and consensus building. Planning is based on the DIP and issues emerging from field experience. Annual plans are developed and followed by more detailed trimester workplans.

d) Partnerships

Much improvement was visible in the partnership between Concern and the District Health Department. A mutual understanding of the project aims and activities has been developed. At this stage the partner is expressing a high level of satisfaction with Concern/CSP and more acceptance of the capacity building nature of the relationship. Roles and plans are clear and that there is now a better level of coordination and joint problem solving.

Concern continues to actively support the coalition of NGOs working in Butare. The group holds meetings on a monthly basis with rotating NGO leadership every three months.

A formal capacity and partnership assessments is planned in November 2003 with the Kibilizi District Health Team.

e) Coordination with other USAID Initiatives

The local USAID mission has been very active in bringing together all organizations receiving US-government financial support to facilitate communications and scale-up successful approaches and tools.

Four PVOs, Concern, IRC, PSI, and World Relief manage centrally-funded Child Survival & Health Grants (CSHG) covering different geographic areas of the country. These PVOs have formed a CSHP Working Group that meets monthly. This coordination was presented at the Annual CORE meeting in April 2003. The local USAID mission and UNICEF participate in these meetings.

USAID/R also invites CSHP PVOs to participate in monthly cooperative agencies' (CAs) meetings to facilitate coordination and collaboration. CAs in Rwanda includes PRIME II, Family Health International, Population Services International and CARE. Quality Assurance assessment tools, social marketing of condoms, and care and support strategies for HIV/AIDS have been fruits of this collaboration. Concern has participated in PRIME II national working groups on Mutuelle's.

f) Other

In June 2003, Concern Worldwide Inc. US conducted its second Institutional Strengths Assessment (ISA) with facilitation from CSTS and Concern Worldwide's Policy Development and Evaluation Department Director. This was a follow-up to the February 2001 ISA.

Overall Findings

- Generally high capacity to provide technical support for programs and application of policy
- Organisational learning moving up as a performing capacity area since 2001 but lots of recommendations on how to improve
- Administration and Human Resources continue to be least performing areas
- Some concerns about accessibility of financial reports for management
- Continued need to support fields with project management skill building.

Intervention Areas	**Perceived Field Need for Health Unit Support**		**Perceived Provision/Receipt of High Quality Support**	
	HQ	*Field*	*HQ*	*Field*
Pneumonia Case Management/ARI	5.5	10	6	10
Maternal & Newborn Care	5.3	10	8	9.7
Nutrition and Micro-nutrients	4.7	10	8	9.7
Malaria Case Management	5	10	7.3	9.5
Reproductive Health/Child Spacing	5.5	10	9	9.3
STI/HIV/AIDS Prevention	6	10	8	9.3
Community-Based IMCI	5.7	10	7.7	9.3
Facility-Based IMCI	4.3	10	6.7	9.3

Breastfeeding	4	7	7.7	6.5
Control of Diarrhea Diseases	3	1	8	n/a
Immunization	3.7	1	7	n/a
Tuberculosis Management	5	n/a	6	n/a

The following are key points by capacity area highlighted in the US office action plan:

1. ADMINISTRATION: Better communication with Projects and Overseas regarding USAID requirements on grants

2. ORGANIZATION LEARNING: Review options for improving organization learning in health and microfinance and develop a strategy; Work with HSU/Dublin to organise annual sharing events for key field Health staff and partners; Establish and maintain information on Concern's work in Health and Microfinance Programs on the website; Develop concise articles on key pieces of Concern's work in health and microfinance and disseminate them widely; Establish an (semi) annual newsletter on Concern US supported programs in the field; Advisors complete annual reports summarizing activities; Conduct quarterly program sharing meetings in the New York office (morning coffee, virtual field trips, etc); and more frequent organization learning-related meetings in for Concern Staff in NY.

3. HUMAN RESOURCES: More active involvement by Advisors in the recruitment and retention of field staff; Better assess field staff technical and project management needs in health programs

4. FINANCIAL MANAGEMENT: Better distribution /communication of financial information within New York, Overseas and the Fields

5. USE TECHNICAL SKILLS: NY Health Advisor fully engage in Concern Dublin's Health Program, Planning and Monitoring Group in setting and monitoring standards for Concern's Health and Nutrition Programs; identify/promote successful microfinance and health collaborative activities; Promote, support, and facilitate health staff participation at the national policy level.

HIGHLIGHTS: New Strategies to Increase Bednet Coverage for Vulnerable Populations

New strategies are needed to ensure that the rural poor have access to life protecting bed nets. Over the past 7 years, social marketing strategies have already met the unfulfilled net of low cost bednets, with national coverage increasing from 3% in 1996 to 7% in 2003. Concern Worldwide and its partners are aiming for protected bednet coverage of 20% of pregnant women and children under-5 by the year 2006.

Marked on the event of World Malaria Day on 25th April 2003, Concern launched a special appeal to pregnant women to purchase low cost treated mosquito nets in Kibilizi District, Rwanda. Through national and NGO subsidy, nets could be purchased by pregnant women attending antenatal clinics for $0.40, an amount equivalent of 2-3 days' labor. Suddenly, what was once beyond reach for the majority of pregnant women in the district, became very accessible.

Fully aware that this price subsidy may result in unintended consequences, Concern and the District Health Management Team, maintain high control standards to follow-up on the use of these nets. These measures include a registry of net transactions at each health center, stamping antenatal cards of expecting mothers who purchase a subsidized net, physical stock audits, and quarter household follow-up from a random sample of mothers in the register.

In mid-June 2003 the first assessment of net distribution was conducted. A random selection of 10% of net recipients from each health center register was made to confirm eligibility, net usage, and re-treatment. Project staff spent 4 days following up on 85 mothers. Their findings:

- **97%** of all net sales investigated were to the intended beneficiary (n=83).
- **70% of the nets of pregnant women were observed properly hung** over the bed (n=58).
- **70% of net owners knew the net must be retreated every six months (n=58)**
- **63% of the nets of pregnant women were treated within the past six months. (n=52)**
- 48% of the women reporting having treated, hung and slept under the net within 48 hours of purchase
- 86% knew that proper use of an ITN is a means of preventing malaria

MALARIA DAY OBSERVATION

Nyashiwa Vestine celebrated malaria day in Kibayi on the 25th April this year. Mrs. Vestine is expecting to deliver in about six weeks. This is her ninth pregnancy. She visited the health center just a week ago when she heard that the District was launching an mosquito net initiative at 10% of market cost for pregnant women who attend prenatal care clinic. Hearing about this promotion, Ms. Vestine found every means to obtain a net.

"I am often falling sick with fever. I heard about mosquito nets on the radio and from the Health Volunteer but could not find that kind of money. (The net costs about $5 on the market). When I heard that I could buy a net today if I brought my antenatal care card, I came running... I am poor like so many other women, but we can find a way to save 200 Rfw."

Mrs. Vestine plans to get home quickly so she can treat her net with insectide and put it up over her bed tonight. She was one of 27 pregnant women who purchased a treated mosquito net, part of a District Promotion to

- 74% knew that pregnant women and young children under five were the most vulnerable to the negative health effects of malaria
- All respondents purchased their net for the **agreed price** of 200 Frw. There was no mark up in prices by health staff.

Results of the findings were disseminated at the antenatal clinics and the monthly District Health Team Meeting. While distribution appears to be very good, local stakeholders searched for solutions to improve the treatment, hanging, and early use of the nets. Since these meetings, net treatment sites have been established at the health centers to ensure every net is treated on site prior to bringing it home. A second follow-up survey is planned in October 2003.

Work Plan 2004

(available in Excel format)